The Wooda Surgery

Quality Report

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Date of inspection visit: 2 October 2014
Date of publication: 22/01/2015

This report describes our judgement of the quality of care at this service. It is based on a combination of what we found when we inspected, information from our ongoing monitoring of data about services and information given to us from the provider, patients, the public and other organisations.

Ratings

Overall rating for this service	Good
Are services safe?	Good
Are services effective?	Good
Are services caring?	Good
Are services responsive to people's needs?	Good
Are services well-led?	

Summary of findings

Contents

Overall summary

Letter from the Chief Inspector of General Practice

The Wooda Surgery was inspected on Thursday 2 October 2014. This was a comprehensive inspection.

The Wooda Surgery provides primary medical services to people living in the North Devon town of Bideford, and the surrounding areas. The practice provides services to a diverse population age group and is situated in a residential area of the town.

At the time of our inspection there were approximately 9,000 patients registered at the service with a team of eight GP partners who held managerial and financial responsibility for running the business, working with a managing partner. In addition there was a regular locum GP. The practice is a GP training practice, currently providing training and support for a registrar and a foundation year two (F2) student on placement.

Patients who use the practice have access to community staff including district nurses, community psychiatric nurses, health visitors, physiotherapists, mental health staff, counsellors, chiropodist and midwives.

There was a volunteer patient support service called Wooda Plus. A team of volunteers who provided a befriending service to the whole of the patient population. They also co-ordinated and provided a transport facility for patients to get to The Wooda Surgery and also provided transport to other healthcare agencies including hospital appointments in Barnstaple. This was funded by donations and a fundraising program and mainly benefitted older people.

The opening times are 8am to 6pm Monday to Friday. Patients can make appointments with GPs and nurses after 6pm on Mondays and Thursdays.

We rated this practice as good.

Our key findings were as follows:

- Patients were pleased they could get appointments on the day if necessary, because of the duty system.
- The practice was well-led and had a clear leadership structure in place whilst retaining a sense of mutual respect and team work. There were systems in place to monitor and improve quality and identify risk and systems to manage emergencies.
- There was a high regard for training and encouraging staff to develop their practice.

Summary of findings

- Carer assessments were carried out by a nurse and a health care assistant who had undertaken specialist training. A family carer confirmed that the support for carers was very good.

We saw areas of outstanding practice including:

- The practice provided a high quality service for patients with diabetes, with qualified nurses trained to provide care and support to patients in collaboration with the GPs and health care professionals in secondary care. Using structured education about diabetes, nurses helped patients manage their condition, including management of insulin.
- There had been effective co-working with the Devon-wide adult substance misuse service. The service focused on harm reduction, particularly in the early stages of treatment for people with high-risk lifestyles. Two GPs recently completed the training for the shared care scheme to support this programme, so they could offer long term support to stable patients who were on a drug and alcohol programme, including giving their prescriptions.
- The practice invested in a centrifuge so blood samples could be kept overnight and still be acceptable to the laboratory after collection each morning. This resulted in more flexibility for patients because health care assistants could now appointments to take blood samples in the afternoons as well as mornings.

Professor Steve Field (CBE FRCP FFPH FRCGP)
Chief Inspector of General Practice

Summary of findings

The five questions we ask and what we found

We always ask the following five questions of services.

Are services safe?

Good

The practice is rated as good for providing safe services.

There was a reliable system for distributing updates, drug alerts and new guidance and ensuring staff adhered to them. The practice had a system in place for reporting, recording and monitoring significant events. Action had been taken on learning points to improve care for patients.

There were systems in place to monitor safety and cleanliness of the building and equipment.

There were suitable arrangements for the efficient management of medicines within the practice.

The safeguarding policy was updated to give clear guidance for staff when an allegation had been received.

Are services effective?

Good

The practice is rated as good for providing effective services.

New patients had a structured health assessment and patients with long term conditions had each condition reviewed annually.

Care and treatment was delivered in line with national best practice guidance. The practice worked closely with other services to achieve the best outcome for patients.

Audits had been undertaken to check whether care was being provided in the most effective way and that administrative processes supported the service efficiently. Not all audits had been repeated to check on progress and not all were available to inform staff and trainees of their outcome.

Are services caring?

Good

The practice is rated as good for providing caring services.

Patients spoke positively about the care provided at the practice. They had been treated with respect and care by all staff, who were friendly and always tried to explain issues and treatment options.

Patients told us they were included in the decision making process about their care and had sufficient time to speak with their GP or a

Summary of findings

nurse. They said they felt well supported both during and after consultations, or through any subsequent diagnosis and treatment. Nurses told us they ensured patients understood what they were being told about their condition and gave them leaflets to read and refer to after their appointment

Carer assessments were carried out by a nurse and a health care assistant who had undertaken specialist training. A family carer confirmed that the support for carers was very good.

Are services responsive to people's needs?

Good

The practice is rated as good for providing responsive services.

Patients were happy with the appointments system and with the fact that they could always be seen by the duty team on the day.

Patients had found the staff very helpful in making appointments for example, for blood tests and blood pressure tests. Appointments were usually on time. GPs and nurses were able to give patients the time they needed and always showed personal interest.

There was level entry to the reception area, an accessible toilet, and a level ground floor, so accessibility to the lower floor was good. However, there was little helpful visual signage and information for health promotion was not displayed effectively.

Complaints were recorded and staff had taken action to resolve issues. However, action had not been taken to resolve an issue that might affect patients outside this practice.

Are services well-led?

Good

The practice is rated as good for being well-led.

Lines of communication and accountability were clear. There was regular consultation between GPs. Nurses and administrative staff found it a positive place to work, with a supportive team.

A GP took responsibility as clinical manager for clinical strategic decisions. GPs rotated the position of executive partner annually. Planning for succession was well advanced with a group manager and practice manager already in post in preparation for the retirement of the registered manager later in the year.

Staff were supported to train and develop their practice.

Summary of findings

What people who use the service say

During this inspection we spoke with nine patients using the practice and the leader of the voluntary support group Wooda Plus, who was also a patient of the practice. The practice had provided patients with information about the Care Quality Commission prior to the inspection. Our comment box was displayed and comment cards had been made available for patients to share their experience with us. We received 22 comment cards from patients and 14 responses from patients in response to an article in the local newspaper informing the public or our forthcoming inspection.

Overall patients expressed satisfaction with the service they received, but where patients had experienced problems, we raised this with appropriate staff to see how the practice had responded.

Patients rated the practice and its staff highly. Patients who had been with the practice for many years told us they had never even thought about changing. They said staff knew their medical history which made them feel safe. They knew what their medicines were for and they were reviewed regularly. The annual review for those with long-term conditions was felt to be very useful in discussing the whole person's health. Those with complex or long-term conditions said that communication between hospital consultants and the practice was good and that GPs were prompt in follow-up appointments.

Patients who spoke with us said the staff team had the specialist skills and knowledge needed to treat them effectively and that they found their knowledge was up-to-date. Both staff and patients mentioned that one of the GPs had initiated regular training to update the skills of GPs and nurses so they could work confidently when it was their turn to cover the duty rota, which involved dealing with a very wide range of medical situations that might be urgent.

Patients told us the reception team were always extremely friendly and helpful. Some patients said they had seen many GPs and nurses over the years and have always felt happy with the consultation and the outcome.

Some patients had found the staff very helpful in making appointments for blood tests and blood pressure. However, some patients with a range of difficulties or multiple problems were not helped by systems at the practice which gave them different times and dates for appointments for different aspects of their health.

Patients were happy with the appointments system and with the fact that they could always be seen by the duty team on the day. Patients who wanted to see their own GP understood that they may need to wait a few days. Most did not mind, but several patients with complex conditions said they would ideally prefer to discuss their health issues with their own GP.

Most patients said they were happy with waiting times once they were in the surgery. Patients who spoke with us who were in chronic pain and found the waiting was difficult said that better management of waiting times and information given on why there is a delay would be helpful.

There was a very active voluntary support group called Wooda Plus, which had been working since the practice opened 27 years ago. Patients told us it was doing a tremendous job in providing transport not only to and from the surgery but also to and from hospital or other medical appointments in Barnstaple. There had been a determined attempt to form a Patient Participation Group (PPG) from Wooda Plus, but this group was fully occupied by its current work of transport and social support. Management staff had taken over responsibility for recruitment for a PPG.

Outstanding practice

The practice provided a high quality service for patients with diabetes, with qualified nurses trained to provide care and support to patients in collaboration with the GPs

Summary of findings

and health care professionals in secondary care. Using structured education about diabetes, nurses helped patients manage their condition, including management of insulin.

There had been effective co-working with the Devon-wide adult substance misuse service. The service focused on harm reduction, particularly in the early stages of treatment for people with high-risk lifestyles. Two GPs recently completed the training for the shared care scheme to support the service so they could offer long term support to stable patients who were on a drug and alcohol programme, including giving their prescriptions.

The practice invested in a centrifuge so blood samples could be kept overnight and still be acceptable to the laboratory after collection each morning. This resulted in more flexibility for patients because health care assistants could now appointments to take blood samples in the afternoons as well as mornings.

The Wooda Surgery

Detailed findings

Our inspection team

Our inspection team was led by:

Our inspection team was led by a CQC lead inspector. The team also included a second CQC inspector, a GP specialist advisor and an Expert by Experience. This is a person who has personal experience of using or caring for someone who uses this type of service.

Background to The Wooda Surgery

The Wooda Surgery provides primary medical services to people living in the North Devon town of Bideford, and the surrounding areas. The practice provides services to a diverse population age group and is situated in a residential area of the town.

At the time of our inspection there were approximately 9,000 patients registered at the service with a team of eight GP partners who held managerial and financial responsibility for running the business, working with a managing partner. In addition there was a regular locum GP. Three of the GPs were female. It is a GP training practice, currently providing training and support for a registrar and a foundation year two (F2) student on placement.

There were six registered nurses, three of whom were qualified nurse prescribers, and one of whom was employed as nurse practitioner. Four health care assistants (HCAs) were employed, all qualified phlebotomists. The registered manager was the managing partner, who was planning for retirement later in this year. A group manager was preparing to take on these responsibilities. A practice manager had been recently appointed, and there was a team of administrative and reception staff.

Patients who use the practice have access to community staff including district nurses, community psychiatric nurses, health visitors, physiotherapists, mental health staff, counsellors, chiropodist and midwives.

The opening times are 8am to 6pm Monday to Friday. Appointments are available after 6pm with GPs and nurses by appointment.

The patient population is predominantly middle aged to older patients but includes working age and young families. It is not set in an affluent area. There is a higher than average percentage of patients with multiple long term conditions.

The population is due to grow. There are plans for 4000 new houses to be built in the neighbourhood over next ten years, which will impact on GP resources.

At weekends and when the practice is closed, patients are directed to an Out of Hours service delivered by another provider.

Why we carried out this inspection

We carried out a comprehensive inspection of this service under Section 60 of the Health and Social Care Act 2008 as part of our regulatory functions. This inspection was planned to check whether the provider is meeting the legal requirements and regulations associated with the Health and Social Care Act 2008, to look at the overall quality of the service, and to provide a rating for the service under the Care Act 2014.

Detailed findings

This provider had not been inspected before and that was why we included them.

How we carried out this inspection

Before conducting our announced inspection of The Wooda Surgery, we reviewed a range of information we held about the service and asked other organisations to share what they knew about the service. Organisations included the local Healthwatch, NHS England, the local clinical commissioning group and local voluntary organisations.

We requested information and documentation from the provider which was made available to us before the inspection.

To get to the heart of patients' experiences of care and treatment, we always ask the following five questions:

- Is it safe?
- Is it effective?
- Is it caring?
- Is it responsive to people's needs?
- Is it well-led?

We also looked at how well services are provided for specific groups of people and what good care looks like for them. The population groups are:

- Older people
- People with long-term conditions
- Families, children and young people
- Working age people (including those recently retired and students)
- People living in vulnerable circumstances
- People experiencing poor mental health (including people with dementia)

We carried out an announced visit on 2 October 2014. During this inspection we spoke with nine patients using the service and the leader of the voluntary support group Wooda Plus, who was also a patient of the practice. Our comment box was displayed and comment cards had been made available for patients to share their experience with us. We received 22 comment cards from patients and 14 responses from patients in response to an article in the local newspaper informing the public or our forthcoming inspection.

During our visit we spoke GPs, nurses and health care assistants, managers and administrative staff. We observed how people were being cared for and talked with carers. We observed how the practice was run and looked at the facilities and the information available to patients.

Good

Are services safe?

Our findings

Safe Track Record

The GP who was clinical governance lead for the practice received updates from the National Institute for Health and Care Excellence (NICE), drug alerts and new guidance from the CCG and from educational sources. There was a reliable system for distributing these to health care professionals throughout the practice and checking that they were adhered to. The GPs and nursing staff were familiar with current best practice guidance, accessing guidelines from NICE and from local commissioners. We saw minutes of practice meetings where new guidelines were disseminated, the implications for the practice's performance and patients were discussed and required actions agreed.

The practice's computer system alerted GPs to any outstanding needs for checks to meet their Quality and Outcome Framework targets, which led to good patient care.

The practice had a system in place for reporting, recording and monitoring significant events.

The practice kept records of significant events that had occurred and these were made available to us. There was evidence that appropriate learning had taken place and that the findings were communicated to relevant staff. Staff were aware of the significant event reporting process and how they would verbally escalate concerns within the practice. All staff we spoke with felt able to raise any concerns, and staff of all grades told us they appreciated the open nature of working relationships in the practice.

Learning and improvement from safety incidents

Monthly meetings were held to review any significant events. The review of significant events from the previous year showed learning points had been implemented into working practices to improve care for patients. For example, following a delay in diagnosing diabetes, new protocols were introduced with guidance from a specialist nurse to amend a template used in diagnosing diabetes, to help make timely diagnoses.

Audits carried out by health care professionals had led to changes in care and treatment offered to patients, including life style advice and osteoporosis risk assessment.

Referrals to secondary care had been audited by the clinical governance lead who brought his findings to the monthly clinical education meetings for review.

Reliable safety systems and processes including safeguarding

All GPs had achieved level three in safeguarding training for children and kept their records to contribute to their professional appraisal. We saw certificates showing that reception staff had achieved level one training in safeguarding in January 2014. They said they felt able to identify signs of abuse and had been provided with the contact details for reporting concerns. Nurses had also raised concerns with a patient's GP and discussed with other colleagues who had recently seen the patient. They had taken safeguarding concerns to the safeguarding lead for the practice, but had also referred concerns to the multi-agency safeguarding hub (MASH). A bi-monthly safeguarding meeting was held involving GPs on duty, plus the health visitors and school nurse to assess the care needs of children and families where concerns had been raised.

A past safeguarding alert and subsequent external and internal investigation and analysis had highlighted the need for some improvements at the practice. These included the need to involve the GP lead for safeguarding, improvement to the practice safeguarding policy and guidance, and improvements in communicating with hospital and community staff who share the care of some patients. Nurses and management had been acting on these learning points, there had since been no other alerts.

The practice had a suitable protocol for the provision of chaperones. A chaperone is a member of staff or person who accompanies a patient during a medical examination or treatment. Notices were displayed in consultation rooms to advise patients they were entitled to have a chaperone present for any consultation, examination or procedure where they feel one is required. Staff had been trained to carry out this duty. The computerised patient records included the initials of the chaperone present, which was good practice.

Medicines Management

There was a system in place to give GPs guidance on their prescription practice. Two patients reported mix-ups with repeat prescriptions, otherwise people who spoke with us said they felt very safe and secure with their medicines.

Good

Are services safe?

A GP took responsibility as lead for medicines management. There were efficient methods for managing prescriptions. Patients could make their requests for repeat prescriptions on-line, in person or in writing. All repeat prescriptions were reauthorised by the GP. A patient could phone their GP, and collect a prescription from the pharmacy in an hour.

Audits on prescribing practice had been carried out, with changes made as a result. For example, when a patient's annual review was due, only one month's medication would be prescribed.

No GP drug bags were kept. When GPs needed medicines urgently for a home visit, they collected them from the pharmacy next door.

The nurses' treatment room medicines were overseen by a dedicated nurse who had responsibility for maintaining them in-date. There was a cupboard for non-emergency medicines as needed for injections plus medicines required for minor surgery not requiring refrigeration. No controlled drugs (CDs) were kept on the premises because GPs were able to access a pharmacy situated next door to the practice.

We checked medicines stored in the treatment rooms and medicine refrigerators and found they were stored securely and were only accessible to authorised staff. There was a clear policy for ensuring medicines were kept at the required temperatures. This was being followed by the practice staff, and the action to take in the event of a potential failure was described.

We saw risk assessments were recorded for the oxygen cylinders. A health care assistant had checked all three cylinders each morning. A nurse was responsible for the resuscitation trolley. They had an efficient system that ensured medicines and equipment were available and safe to use in the event of a medical emergency. A monthly check had been completed and a computerised record kept of the equipment and the emergency medicines.

Cleanliness & Infection Control

Patients had observed that the practice was always clean so gave them no misgivings about attending. We observed the premises to be clean and tidy. We noted that the infection prevention and control (IPC) policy and supporting procedures were available for staff to refer to on the practice intranet, which enabled them to plan and implement control of infection measures and to comply with relevant legislation.

Curtains provided for privacy in treatment and consulting rooms were clean. Managers told us they were replaced annually. Labels were dated with the installation date. Pedal bins were provided.

A nurse team leader, a manager and the lead cleaner had been given responsibilities for the management of IPC. Audits had been carried out on the treatment rooms which showed that staff had noticed problems, reported them to the premises co-ordinator and they had been resolved. For example, new seals had been provided around the edges of floors, to provide hygienic surfaces. One treatment room had stains in its floor that would not lift, and this remained on the list of planned work. One treatment room had partial new flooring.

A practice nurse had undertaken monthly spot checks to ensure cleanliness, and supplies of personal protective equipment (PPE). Staff told us the bins had been replaced in response to findings of an audit. The IPC nurse lead said they checked the GPs practice and consultation rooms to ensure procedures were followed. If they found any shortfalls, for example sharps boxes or bins overfilled, they emailed staff to bring it to their attention.

The IPC nurse lead had carried out spot checks on staff annually which had included their practice on IPC. Training was included in training for all new recruits within four weeks of starting work at the practice. We saw records showing that clinical staff's immunisation and Hep B status were kept up to date.

Clinical waste was stored securely and disposed of legally. A nurse checked regularly to ensure the correct clinical waste bags were used. Each room had a flowchart showing staff which bin to use for any item.

The practice had introduced Department of Health guidelines about Ebola. A GP had written a policy and procedure for staff in the event of suspecting a patient may have Ebola. An infection control pack was kept in the treatment room, providing gloves, visor, apron, face mask. Consideration was being given to providing complete overalls. A spill kit was also kept in the treatment room. In

event of spillage of bodily fluids, reception staff were instructed to alert the duty nurse. Reception staff did not have proven immunity to Hepatitis B so did not clear up spillages.

The premises had been tested for Legionella in July 2014, and a notice was displayed in the waiting room to inform patients.

Environmental cleaning of the communal areas was carried out every evening, under a contract. Audits had been carried out by the company. The premises co-ordinator had recently attended training on IPC with a staff member from the company and used the opportunity to get to know their systems and build a good working relationship.

Equipment

Staff told us of their procedure for checking they had the equipment they needed for any clinic and the procedure for reordering. Staff had access to supplies of protective equipment such as gloves and aprons, disposable bed roll and surface wipes. There was a system in place to prevent shortages and to ensure that stock was rotated.

A nurse was responsible for calibration of equipment. The premises co-ordinator checked the air conditioning, and burglar alarm, and the utilities.

Instruments needing to be sterilised were prepared for collection and transport to a central decontamination service each morning. There was a system in place to account for each instrument, and to identify the patient and GP by whom it was used, in case IPC issues arose. Return of the instrument to the practice was also accounted for.

Staff gave an example showing that the practice acted on staff ideas. The computer had been placed on the work surface in a treatment room. This was bad for keeping the work top clear and clean, as well as being bad for staff posture and bad because staff had to stand with their back to the patient when using the computer. Staff working in this treatment room suggested a desk or small workbench for the computer and it had been provided.

Staffing & Recruitment

Staff told us there were suitable numbers of staff on duty and that staff rotas were managed well. The practice had a low turnover of staff. The locum employed at the time of this inspection had worked with the practice over the past year as their registrar so was well known to staff and patients. GPs told us they also covered for each other during shorter staff absences.

Recruitment procedures were safe and staff employed at the practice had undergone the appropriate checks prior to commencing employment. An initial judgement was made at interview about the candidate's clinical competence through discussion of their previous experience. Once in post, staff completed an induction which consisted of ensuring staff met competencies and were aware of emergency procedures.

The registered nurses' Nursing and Midwifery Council (NMC) status was completed and checked annually to ensure they were listed on the professional register to enable them to practice legally as a registered nurse. Managers had checked GMC registers and qualifications for GPs. We saw they had made appropriate checks for the current locum GP.

Managers had followed guidance on a website provided by the NHS on employment, which included advice about risk assessment during the recruitment process. Their policy included checking the person's right to work in the UK though they had not employed overseas staff. They had not routinely applied for criminal record checks for administrative staff. All were trained in chaperoning. A risk assessment had been carried out on the decision to give administrative staff the role of chaperone, for example including the instruction to GPs and nurses that these staff were not to be alone with the patient. We looked at a sample of records of staff who had been recruited recently. Records we looked at contained evidence that appropriate recruitment checks had been undertaken prior to employment, with the exception that not all references that had been requested from previous employers had been received.

First day induction for all staff included data protection, information and computer safety, safety around the building, security, routines and responsibilities including fire testing. Every new nurse had clinical training with the clinical manager.

Monitoring Safety & Responding to Risk

Emergency lights and fire alarms had been checked professionally in accordance with a service agreement that ensured continuing safety. The alarms had been checked

weekly by staff in the practice. Fire extinguishers and sprays had also been serviced professionally. Fire safety training, including drills had been provided annually, most recently in March 2014.

The fire risk assessment for the building was not available for inspection. A manager booked an independent assessment to take place in the week following this inspection. A staff member had been given responsibility for monitoring safety of the building, to ensure safety would be maintained. There was a procedure in place that gave responsibility for responding to fire alarms to the receptionist on the front desk. The administrative team had a health and safety officer who was responsible for checking the fire folder regularly.

Arrangements to deal with emergencies and major incidents

The practice had arrangements in place to manage emergencies. We saw records showing all staff had received training in basic life support. A qualified first aider was on duty and further courses for first aid had been booked so that this presence could be maintained whenever the practice was open.

Emergency equipment was available including access to oxygen and an automated external defibrillator (used to attempt to restart a person's heart in an emergency). All equipment needed was present and available for action. All staff asked knew the location of this equipment and records we saw confirmed these were checked regularly.

A GP set a scenario for staff training, with a medical emergency in the waiting room. Staff did not know this was going to happen. The purpose was to test how staff responded and the learning point for the practice was that staff needed to be more familiar with the kit and clearer about their own role. They found this session was very useful and helped identify the role that different staff should take on in the event of a medical emergency.

A record had been kept of medical emergencies, including what happened and what drugs were used, and scanned into the patient's record. A central log of significant event analyses (SEA) was made, so that the learning could be shared amongst the team, and not lost. An SEA was held for a resuscitation that had gone really well, so that this learning could be kept and shared. A member of staff took responsibility for recording SEAs and organising the meetings.

Emergency response bell was installed on reception so staff could summon assistance. In treatment rooms the computer provided a system for calling for assistance from other staff on the premises.

A business continuity plan was in place to deal with a range of emergencies that may impact on the daily operation of the practice. GPs had a copy to keep with them. It included key information about who to contact.

The plan had assessed the risks of loss of computer system, telephone system, the loss of key staff, major epidemic, failure of key supplier, loss of water or electricity and any other event that would cause the premises to be inaccessible. Specific plans had been drawn up to give staff guidance on how to respond to maintain safety for patients and staff.

The practice had close working relationship with a neighbouring practice and could access patient records via their system if necessary, for example, when once there had been a problem with burst pipes causing a flood. In the event of snow, staff had gone to work in the practice that they could get to safely.

Good

Are services effective?

(for example, treatment is effective)

Our findings

Effective needs assessment

Patients were confident that staff know their medical history and said that they felt safe and they had been given the right medications for their conditions. They knew what their medication was for and it was reviewed regularly. The annual review for those with long-term conditions was felt to be very useful in discussing the whole person's health. Those with complex or long-term conditions said they had found communication between hospital consultants and the surgery to be good and that GPs were prompt in arranging follow-up appointments and called patients back if necessary for review or discussion.

Newly registered patients were offered a new patient consultation. The new patient history template showed that a structured approach to needs assessment was followed, including the medicines history, family and social history and occupation. A recognised method for assessing pain was used, that looked at what made it better or worse, what sort of pain was felt, where it was felt, the severity and timing. Patients views about treatment and any concerns they had about their health were recorded.

Nurses undertook annual reviews of patients with long term conditions so the patient would not have an appointment with the GP unless it was needed due to a change or deterioration. This provided continuity of care for the patient as often the nurse knew the patient well and had a good understanding about the patient's long term condition. Patients were seen for each individual condition because nurses offered specialist knowledge in certain conditions in order to achieve improved outcomes for patients.

The practice had a system in place for carrying out clinical audits. For example, there had been an audit on Lithium prescription, and though there had not been a follow up audit to complete the cycle, GPs had observed improvement in their patients. GPs had carried out a Proton Pump Inhibitor audit and made changes for their patients including lifestyle advice risk assessment for osteoporosis and health education for patients. They planned to complete the audit cycle in 2015. One GP told us they had done an audit of about the use of statins for people with high cholesterol who also had diabetes and repeated it to complete the cycle. The practice should consider storing records of the audits more accessibly to provide a resource for students, trainees and staff at the practice.

The practice used the quality and outcome framework (QOF) to measure their performance. The QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice in their surgeries. The practice had managed their responsibilities under the Quality and Outcomes Framework **(**QOF**)** by a staggered annual programme. This enabled the practice to monitor patients over the year and recall them for reviews appropriately. Some QOF targets were changed periodically. This year the indicators for patients' retinal screening was no longer included in these targets, but the practice recognised the importance to patients and continued to provide an annual space for the retinal screening team to provide their service at The Wooda Surgery.

We saw no evidence of discrimination when making care and treatment decisions. Interviews with GPs showed that the culture in the practice was that patients were referred on need and that age, sex and race was not taken into account in this decision-making.

Management, monitoring and improving outcomes for people

The practice provided a service to up to 9,000 patients. The practice were keen to ensure that staff had the skills to meet patients' needs. For example, nurses had received extensive training including immunisation, diabetes care, cervical screening and travel vaccinations.

GPs in the surgery undertook minor surgical procedures in line with their registration and NICE guidance. The staff were appropriately trained and kept up to date. There was evidence of regular clinical audit in this area.

The practice ensured that nurses were able to complete cycles of care. All qualified nurses at practice were prescribers. They found that as a prescriber in a duty team they could provide a better service for patients. They would triage, and then consult with the GP. They could prescribe any medicines within their competence unless a patient was on a programme to overcome addiction. They

consulted the North East Devon Formulary but could consult with a GP to prescribe if dealing with a condition where they were still developing competence (e.g. epilepsy).

A nurse practitioner and two trained nurses were qualified in treatment of diabetes and could provide care and treatment to help patients manage complex health conditions. Using structured education about diabetes, the nurse practitioner considered the options in discussion with the patient. She referred to consultants, dieticians and chiropodists at the hospital in order to negotiate what was right for the patient to manage their condition, including management of insulin.

The voluntary support group Wooda Plus had bought a duplex machine and nurses had established a wound care pathway. The practice was now able to fast track patients into wound care pathway and into compression dressings so that patients were not waiting weeks for dressings. All patients had a Doppler assessment to define a safe level of compression bandaging within two weeks, leading to quicker healing. Staff set up a template to use on patient records to ensure all checks were completed. They told us they had built a good relationship with the tissue viability nurse who had come in to see patients at the practice so they did not have to go to the hospital.

Audits had been carried out of nurse appointments and health care assistant appointments in the treatment rooms, looking at the numbers and types of appointments offered and the number of patients failing to arrive. This information was used to make a judgment about how best to use nurse hours. For example, the audit showed insufficient capacity for the carers' checks that had been introduced, resulting in offering extra hours and a nurse increasing their working hours for this purpose.

The provision of blood pressure appointments were considered to see if these needed to be increased or reduced and whether these appointments were needed. It was decided to keep these appointments because it met best practice to offer this type of appointment.

The practice invested in a centrifuge so blood samples could be kept overnight and still be acceptable to the laboratory after collection each morning. This resulted in more flexibility for patients because health care assistants could now appointments to take blood samples in the afternoons as well as mornings.

Administrative staff had carried out audits. Qualitative review of letters had been carried out and the speed of referrals increased. Staff checked the records of patients with chronic conditions. For example, if the blood pressure result was not in range, they checked there was a plan in place to improve this, and if not whether staff were checking it. A practice nurse audited reviews to ensure they were carried out at the right time.

Staff recognised that the out of hours service used a different template for special messages. If a person was receiving palliative care, this could lead to missed messages. Staff had introduced a method to avoid this problem.

Effective staffing

A duty system was in place to meet patients' urgent needs every day. One GP took over from another at 1pm to retain focus throughout the day as it was such a pressured job. A nurse was available as part of the duty team each morning. The duty GP was a single point of contact for all emergency care taking calls, discussing issues with paramedics, visiting care homes for people with learning disabilities as well as seeing urgent patients. This was good for patients, as it took emergencies away from regular doctoring. It improved the continuity of care for people, as patients were more likely to be able to see their own GP if they were not in an emergency.

Patients found that the staff team had the specialist skills and knowledge needed to treat them effectively and that their knowledge was up-to-date. Both staff and patients were pleased to tell us that the GP lead had initiated quarterly structured education training for the duty team. This updated the skills of staff so they were confident when it was their turn to cover the duty rota, where they would be presented with arrange of health care problems, some of which might be unexpected.

The practice was a GP training practice. One GP in training told us they found the team extremely dedicated, encouraging and supportive, saying they ensured patient safety throughout the training and enabled the trainee GP to review and improve their work.

GPs were qualified and expert in a wide range of areas, including minor surgery and understanding patients with autism. The nurses had experience of working in a variety of other settings including accident and emergency and intensive care units.

Good

Are services effective?

(for example, treatment is effective)

A practice nurse with an overview of the treatment room project looked at capacity of health care assistant and nurse appointments. She ran monthly reports and six monthly meetings to review the provision of appointments and to consider how to adapt the service for the next six months. This method was to address issues rationally and systematically. A new rota system was introduced following a decision to employ a fourth health care assistant. The meeting called for the following month was to consider how changes impacted on workloads.

Working with colleagues and other services

Once a month there was a multidisciplinary team meeting to discuss vulnerable patients, high risk patients and patients receiving end of life care. This included the multidisciplinary team such as physiotherapists, occupational therapists, health visitors, district nurses, the hospice nurse, palliative care nurses and the mental health team. This meeting worked to provide integrated care and avoid unplanned admissions to hospital. Staff who spoke with us demonstrated they were keen to seize opportunities to work with other health care professionals for the benefit of their patients. An example of shared care was a patient with a learning disability was able to give consent to treatment to their leg being carried out, while they were under a general anaesthetic for another unrelated procedure.

The practice had a bi-monthly meeting with school nurses, health visitors, the local drug and alcohol service, and depression and anxiety service. GPs and staff were working in partnership with another GP practice in Bideford. Patients could be referred to North Devon District Hospital, Barnstaple or the Royal Devon and Exeter Hospital, Exeter. The practice had built up working relationships with many care homes.

GPs and nurses met informally every morning, for half an hour which allowed for queries and concerns to be discussed. GPs representing the practice attended commissioning meetings and a regional GP forum.

Patients said referrals and follow up appointments for specialist treatment were prompt and efficient and the voluntary group at the surgery provided transport. A patient who was relatively new to the practice said they had a very quick referral for hearing problems and that communications were very clear.

Practice nurses worked closely with the diabetes team at North Devon District Hospital. They were able to make direct referrals. This resulted in a high quality service to patients. When patients with diabetes failed to attend and appointment, staff would follow this up to ensure they did not miss essential treatment.

Health Promotion & Prevention

Vaccination clinics were organised on a regular basis which were monitored to ensure those that needed vaccinations were offered. Patients were encouraged to adopt healthy lifestyles and were supported by services such as the smoking cessation session that was provided on the day of this inspection.

Leaflets on many health conditions including contraception and organ donors were on a rack on the corridor wall leading to treatment rooms. The racks of leaflets were not displayed in a manner that would attract peoples' attention. There was information about carers' services available at reception, but we did not see that this was actively promoted. No information was displayed at the entrance or behind the receptionists desk. There was no assistance for patients with visual problems. Staff said a hearing loop was on order.

A screen was provided in the waiting room, giving information about health related topics, including Wooda Plus. Patients found the display complicated. There is no permanent or temporary visual display to promote initiatives. For example, it was the season for 'flu vaccinations. The only reference to this was small print information sheets. The practice would benefit from developing the presentation of health promotion information for patients.

Good

Are services caring?

Our findings

Respect, Dignity, Compassion & Empathy

During this inspection we spoke with nine patients using the service and the leader of the voluntary support group Wooda Plus, who was also a patient of the practice. A CQC comment box was displayed and comment cards had been made available for patients to share their experience with us. We received 22 comment cards from patients and 14 responses from patients in response to an article in the local paper informing the public or our forthcoming inspection.

Overall patients expressed satisfaction with the service they received, but where patients had experienced problems, we raised this with appropriate staff to see how the practice had responded.

Patients told us they felt their care was excellent, second to none. They had been treated with respect and care by all staff, who were friendly and always tried to explain issues and treatment options.

Patients were seen in separate and private rooms by GPs and nurses. They told us they were always treated well and their privacy and dignity was always respected. The receptionists were polite and friendly.

A notice at reception advised that patients could have privacy at reception by asking the receptionist. However, one patient explained that when they were querying a prescription, the receptionists may require personal information at the reception desk where there was no privacy.

We observed staff were careful to follow the practice's confidentiality policy when discussing patients' treatments in order that confidential information was kept private. All staff took care with computer screens, for example, the clinic list was minimised on the screen so other patients would not be able to identify the names of other patients on the list. A partner was designated as Caldicott Guardian for the practice, responsible for protecting the confidentiality of patient information and enabling appropriate information-sharing.

We discussed the use of chaperones to accompany patients when consultation, examination or treatment were carried out. A chaperone is a member of staff or person who accompanies a patient during a medical examination or treatment. Posters displayed informed patients they were able to have a chaperone should they wish. Nursing and administrative staff at the practice acted as chaperones as required. They had received training and understood their role was to reassure and observe that interactions between patients and doctors were appropriate. The computerised patient record saved the initials of the chaperone present, which was good practice in case any concern was raised at a later date.

Care planning and involvement in decisions about care and treatment

Nurses told us they ensured patients understood what they were being told about their condition and gave them leaflets to read and refer to after their appointment. The patient record showed when reference to written information or websites had been given. Patients were encouraged to bring a family member or other supporter with them if it helped for instance at the time of a new diagnosis of diabetes. Patients were advised they could phone the practice with any query or concern. Care plans had been written for some patients with complex care needs including COPD and asthma.

There was good understanding within the practice of patients with learning disabilities. Patients who lived in care homes were encouraged to come to the practice for their appointments.

GPs demonstrated their understanding of consent. They described how expectations had moved on from accepting implied consent when patients came for their appointments. Now verbal consent about specific treatments was recorded with a box on the patient record template to show informed consent given for example to smear tests or ear syringing.

Written consent from patients was required for minor operations for ingrown toenails. Any risk of complications was discussed with the patient. All GPs had received training on the Mental Capacity Act 2005. Nurses described a recent example of a best interest meeting (BIM) held for a patient with learning disabilities, to consider whether it was in their best interests to have a smear test. Family and carers were involved in the decision, which took into account the patient's personal risk status. Nurses had

Good

Are services caring?

made judgements about how much a patient had understood if other staff have raised concerns for patients seen regularly and whose capacity for understanding or retaining information was deteriorating.

Staff could not vaccinate babies and children unless their named parent was with the child or there was written evidence from the parent.

Patient/carer support to cope emotionally with care and treatment

A patient who spoke with us said their GP had phoned them twice for support since a death in the family. A family carer confirmed that the support for carers was very good.

For patients who were receiving palliative care at the end of life, arrangements were in place for them to receive prescriptions as they needed them, from any authorised prescriber in the practice, to avoid any delay.

Receptionists had information to give to people who requested it, to help people define themselves as a carer. A carers identification questionnaire was provided along with an information leaflet provided by Devon Carers Voice, part of Healthwatch Devon.

Carer assessments were carried out by a nurse and a health care assistant who had undertaken specialist training. They were actively validating the carers' register and inviting people in for assessments. This involved an hour long appointment in which to assess the person's needs and signpost them to services. Staff had a named worker at Devon Carers to liaise with, for further advice and support. Managers told us there was no differentiation based on the age or health condition of the patient being cared for.

Good

Are services responsive to people's needs?

(for example, to feedback?)

Our findings

Responding to and meeting people's needs

Patients were happy with the appointments system and with the fact that they could always be seen by the duty team on the day. The system was initiated in 2009. One of the GPs described how accessible the service was, as people could come in, register and see the duty team within a few minutes. Consultations had gone up by 40% over five years with this system. The duty GP was a single point of contact for all emergency care and was available all day. One GP took over from another at 1pm to retain focus throughout the day. A nurse was available as part of the duty team each morning. The nurse collected a full set of observations, collated the information into the triage assessment and referred the case to the GP.

Parents commented how helpful the duty team had been. They had found with their children that problems had arisen suddenly, maybe overnight. When patients wanted to see their own GP they understood that they may need to wait a few days, and most didn't mind, but several patients with complex conditions said they would ideally prefer to discuss issues with their own GP.

Patients had found the staff very helpful in making appointments for example, for blood tests and blood pressure tests. Appointments were usually on time. GPs and nurses were able to give patients the time they needed and always showed personal interest.

The administrative staff had taken on specialist roles to ensure good practice. For example, one staff member took the lead role in making patient referrals to secondary care using a computer based system and getting referrals out the same day. Specific time set aside for specific roles, which also included a lead worker for the recall system, another for cervical screening, and a plan to develop a role to utilise a staff members experience in pharmacy. These arrangements made access to services more timely for patients.

Nursing staff had audited the appointments booked and used in the treatment rooms, to assess whether they were offered in the most appropriate way. This was kept under review and adjusted in order to provide staff and time for the services most needed by patients.

Staff also audited the instances of patients failing to arrive for their appointment. They found most were due for dressings, immunisations, or contraceptive reviews. A 24 hour advance telephone call was introduced to remind patients of these types of appointments.

There was a very active voluntary support group called Wooda Plus, which had been working since the practice opened 27 years ago. It was providing transport not only to and from the surgery but also to and from hospital or other medical appointments in Barnstaple. There had been a determined attempt to form a Patient Participation Group (PPG) from Wooda Plus, but this group was fully occupied by its current work of transport and social support. Management staff have taken over responsibility for recruitment for a PPG.

On discussing the findings of the previous year's patient survey with Wooda Plus and outlining the significant pressure points on the telephone calls to the Practice during peak times, the practice agreed to discontinue the repeat prescription line from January 2014, in order to free up a telephone line available for incoming calls at peak times for patients accessing the practice. It was agreed that the practice would promote the online prescription and electronic prescribing services to patients.

Tackling inequity and promoting equality

The practice had recognised the needs of different groups in the planning of its services. Staff said no patient would be turned away. Because of the duty system in place, the service was accessible to all. For example, a homeless family were able to see a GP within 20 minutes.

The number of patients with a first language other than English was low and staff said they knew these patients well and were able to communicate well with them. The practice staff knew how to access language translation services if information was not understood by the patient, to enable them to make an informed decision or to give consent to treatment.

A member of staff, working nine hours per week, had been given responsibility for the patient noticeboard, displays and presentations and website updates. Their duties also included safety of the building and maintenance of equipment, IT issues and public information. Promoting equity by sharing information was not yet achieved. There was no permanent or temporary visual display to promote initiatives. No information about support for carers was on

Good

Are services responsive to people's needs?

(for example, to feedback?)

public display although the practice offered the carer checks and supported carers in signposting what help was available to them. The large screen displayed quite complex information which people might need but which some patients found was difficult to take in and should be also offered in alternative formats.

Access to the service

When asked what they might improve about the service most people could not think of anything, but several expressed concern that the current building is already working at beyond capacity for space. As the local population was scheduled to expand considerably because of new building schemes, patients were concerned that the current service they received may be adversely affected.

There was level entry to the reception area, an accessible toilet, and a level ground floor, so accessibility to the lower floor was good. However, there was little helpful visual signage. Patients with learning difficulties visiting the practice would not be helped by the lack of accessible information. Priority in the waiting room had been to make it welcoming and attractive, with fresh flowers, pictures and a children's play area.

People said they are happy with waiting times once they were in the surgery. They could sign in on a touch screen. A patient who was in considerable pain had believed they were signed in on-screen. After waiting thirty minutes they spoke to the receptionist and found they had been recorded as not turning up. The screen had not got a clear way of letting patients know whether they had successfully signed in. This may be likely to happen when people are in pain or distress. On the day of this inspection, few people were waiting more than a few minutes, once they had signed in.

The number of patients with a first language other than English was low and staff said they knew these patients well and were able to communicate well with them. The practice staff knew how to access language translation services if information was not understood by the patient, to enable them to make an informed decision or to give consent to treatment. There was a language board so patients identify their language for staff. Staff said they had used a computer based search engine to find a translator for patients making appointments. Staff also gave us the example of a patient recently returned from holiday who brought their discharge letter into the practice. Staff sent the letter away to a translation company.

Normal opening times for the practice were 8am to 6pm. Evening appointments with GPs were offered on Tuesdays and Thursdays from 6.30-7.30pm. Nurses offered evening appointments if necessary, for example removing stitches, if the patient could not get to the practice earlier.

Listening and learning from concerns & complaints

The practice had a system in place for handling complaints and concerns. Their complaints policy was in line with recognised guidance and contractual obligations for GPs in England and there was a designated responsible person who handled all complaints in the practice.

A laminated statement of the complaints policy was displayed beside the reception desk. No patient who spoke with us had ever had cause to complain and they were not sure what to do if they needed to complain. Staff told us that when a patient brought a verbal complaint to the attention of reception staff, the reception manager put it into writing and passed it to the practice manager.

A comments book was on the reception counter. Managers checked it every week. Staff told us that informal feedback, positive and negative, was discussed at management meetings, was taken very seriously and followed up with patients to resolve as fully as possible.

The practice manager provided the review of complaints from the year to 31 March 2014 and the minutes of the management meeting when they were considered by the team leaders. Staff noted there had been more than one complaint about a health care professional. The team agreed they would not employ this person to work within the practice, but there was no mention of escalating concerns to NHS England, to protect patients using other services.

Are services well-led?

Good

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

Our findings

Vision and Strategy

The practice had a clear vision to deliver high quality care and promote good outcomes for patients. The aims were specified in their statement of purpose. Staff knew and understood the vision and values and knew what their responsibilities were in relation to these. Managers told us they were well supported by the partners. GPs said they found The Wooda Surgery provided a stimulating working environment, where patients' well-being was put first.

Lines of communication and accountability were clear. Partners and staff told us they appreciated the open communication within the practice. A GP told us the culture had changed over the past years and there was regular consultation between GPs. Nurses and administrative staff found it a positive place to work, with a supportive team. Staff's interests were promoted and their skills developed. Partners told us they were proud of their commitment to staff progression and had funded training for nurse prescribers and nurse practitioners' training.

Governance Arrangements

Staff were familiar with the governance arrangements in place at the practice and said that systems used were both informal and formal. Any clinical or non clinical issues were discussed amongst staff as they arose. Clinical governance meetings were held every Monday at 1pm, with agendas planned well ahead. We looked at minutes from the last two meetings and found that performance, quality and risks had been discussed. Significant events, NICE guidelines, QOF, and clinical education were regular agenda items. Health care professionals had been invited, including guests from the hospice and from the drug and alcohol service. Staff told us that every week they were sent an email with minutes of the Monday meeting so they knew what had been done and said and what was being done about it. Actions were highlighted for individual staff.

The practice used the Quality and Outcomes Framework (QOF) to assess quality of care as part of the clinical governance programme. The QOF is a voluntary system where GP practices are financially rewarded for implementing and maintaining good practice in their surgeries. A GP said that despite constantly moving goalposts the QOF achievements were always high which showed their commitment as a team to providing an efficient and high quality service.

Leadership, openness and transparency

GPs rotated the position of executive partner annually, to lessen the responsibility of the senior partner and to share experience so that younger partners learnt about the business side of practice. Planning for succession was well advanced. The registered manager was preparing to retire later in the year. A group manager had been appointed, who would register with CQC, and a practice manager was also in place. A GP took responsibility as clinical manager to take responsibility for clinical strategic decisions.

A GP partner joined the managers and team leaders for management meetings to discuss operational issues, such as the 'flu vaccination campaign. Participants described this meeting as supportive. The teams had their own meetings. The reception team met monthly and the treatment room (TR) group meeting was held monthly. For example, qualified nurses had introduced a new protocol about dressings to the TR team.

The practice had a system of internal peer review. GPs reviewed colleagues' referrals and prescribing practice.

Practice seeks and acts on feedback from users, public and staff

We met the leader of Wooda Plus, the organisation set up 27 years ago to provide social support for older people. The transport service had grown over the years, provided entirely by patient volunteers. They have charity status. They ask patients for donations for their journeys.

An open week had been held to promote a PPG group, as the current organisation is fully occupied with its current tasks. 100 people had agreed they will give feedback. The practice manager was leading this work until a patient representative was available.

Feedback gathered had included waiting times and difficulties with getting through on the phone.

The practice had carried out a patient survey exercise as a result of which additional appointments had been made to accommodate working hours.

Staff gave good examples of how staff feedback was listened to. Regular team meetings enabled concerns to be

Are services well-led?

Good

(for example, are they well-managed and do senior leaders listen, learn and take appropriate action)

addressed, for example, the appointment system was not taking account of the time it took to do leg ulcer dressings. This was raised and the appointments had been extended to 30 minutes to accommodate this.

A GP said they listen to our patients when they feed back to us regarding what we do well and what we have not done so well and we learn from these experiences and offered a high standard of care in a caring and safe environment.

Management lead through learning & improvement

A staff intranet was provided so that staff had access to policies and procedures for their guidance at any time.

The practice was a GP training practice, currently providing training and support for a registrar and a foundation year two (F2) student on placement. The GP registrar was provided with two one-hour tutorials per week, plus advice and guidance as required. A GP had attended a course to support medical students, who will soon be joining the practice with professional oversight from Plymouth University Peninsula School of Medicine. This meant the practice will have trainees at three levels of competence.

The practice manager had devised a weekly timetable for the building, as health care professionals worked in different consultation rooms and treatment rooms to maximise the use of the building and services provided to patients. This was displayed so that all staff and especially the GP in training knew where their supervisor was at any time. The registrar had supervision with a named GP, recorded on this rota.

Quarterly practice lunchtime education meetings were held and guest speakers and trainers attended. Staff contributed requests and discussion topics for learning points which had included risk assessment in respect to mental health, and improving the quality of assessment histories.

After their initial induction, staff had been placed on a training schedule appropriate to their role. All new staff had a training buddy for the first six months. Three month, six month then annual reviews were held for all new staff.

Managers were in the process of creating a competency framework for reception staff. Managers had changed the provision of mandatory training, and now all staff attended during February, so they did not need to check the records so frequently. This included on-line Moving and Handling training, provided by Skills for Health. Managers had a record of staff who had attended training and a spreadsheet showing training plans and achievements. All receptionists had taken turns to train new recruits. Training in equality and diversity had not yet been delivered, but plans were in place to provide this.

The TR team leader had observed health care assistants carrying out their tasks and procedures to assure their competency. One staff member told us it was good to have this, to make sure they were working properly. They were pleased to have a competency check on their return to work after an absence.

New nursing staff were entered on General Practice Nurse Education programme run by Plymouth University. This course gave specific grounding to working in general practice and was accredited. Health care assistants were supported to develop in their roles.

A practice nurse told us they were studying for an MSc in advanced care practice, supported by the partners and management team.

GPs told us that their appraisals were co-ordinated. They had carried out 360 degree feedback and found it helpful, constructive, and mutually supportive. No partners have been revalidated yet

All staff received annual appraisals, provided by their team leader. We saw a sample, covering development and review, plans with target dates, evidence of achievement and learning points.

This section is primarily information for the provider

Enforcement actions

Action we have told the provider to take

The table below shows the essential standards of quality and safety that were not being met. The provider must send CQC a report that says what action they are going to take to meet these essential standards.